Cook Chiropractic, Inc.
1509 7th Street
Bay City, Texas 77414
979-244-2900

NEW PATIENT INTAKE

Name:____Date:____________

Address:_________________________________City:___________________State:________Zip:______

Home Phone: (   )_______________   Work: (   )________________   Cell: (   )_________________

May we use text messaging for appointment reminders?   Y   N

Email Address____   Male_______   Female______

Social Security:___________________________Birthday:___________________________Age________

Occupation:____

Employer Name and Address:____

Single ( )   Married ( )   Divorced ( )   Spouses Name:____________________________________

Have you seen a Chiropractor before?   Yes ( )   No ( )   When?______________________________

Whom may we thank for referring you to our office?____

YOUR HEALTH SUMMARY

List any medications you are taking:____

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability______

Check all symptoms you have ever had, even if they do not seem related to your current problem

Pins and Needles in arms
Hot Flashes
Dizziness/loss balance
Heartburn/Stomach upset
Numbness in fingers
Ulcers
Fatigue
Fever
Sleeping problems
Irritability
Diarrhea
Back pain
Cold sweats
Fainting
Constipation

Mood Swings
Problem urinating
Pins and Needles in legs
Muscle Spasms neck
Loss of smell
Muscle Spasms _________
Shoulder pain Left Right
Neck Pain
Lights bother eyes
Knee pain Left Right
Buzzing/ringing in ears
Numbness in toes
Depression
Neck stiff

PATIENT SIGNATURE:____

GUARDIAN SIGNATURE:____

Cook Chiropractic, Inc.
Confidential Patient Information

Today's Date:____

Patients Name:____ Date of Birth:_____________

CONSENT TO TREATMENT

___I am the patient ___I am the parent/legal guardian of the patient ___other___________________

I hereby authorize such chiropractic care, treatment and diagnostic tests as may be recommended by Dr. Katherin Cook and/or associate doctors affiliated or employed by Cook Chiropractic, Inc. to ( )myself or ( )my minor child and understand there is no warranty or guarantee of result of cure. This consent will remain in effect until I withdraw my consent in writing.

Name of Minor Child__________________________Age____ ( )Male ( )Female ( )Does not Apply

Signature:____ Date:_______________
Please check the appropriate box: ( )Patient ( )Parent ( )Legal Guardian

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE & FINANCIAL POLICY

___I am the patient ___I am the parent/legal guardian of the patient ___other___________________

I acknowledge that I have received the Office and Financial Policy for Cook Chiropractic, Inc. and agree to its terms.

Signature of Patient/Parent/Guardian:__________________________________ Date:_______________

AUTHORIZATION TO LEAVE RECORDED VOICE MESSAGES

___I am the patient ___I am the parent/legal guardian of the patient ___other___________________

I give my permission for Cook Chiropractic, Inc. physicians and staff to leave messages regarding office visits and appointments as well as any other health care information related to my treatment at the phone number (s) listed below:

Home__________________________ Work________________________ Cell Phone__________________

Signature of Patient/Parent/Guardian:__________________________________ Date:_______________

A photocopy or faxed copy of these authorizations shall be deemed as valid as the original________

COOK CHIROPRACTIC, INC.
Financial Policy

Thank You for choosing Cook Chiropractic, Inc. to provide your health care. We are committed to providing you the best possible healthcare. In order to prevent any misunderstandings, and to serve you better, we ask all patients/guarantors to read and understand our financial policy. We will gladly answer any questions you may have about services provided, fees, financial policy, or any other aspect of your care.

1. Payment is due at the time services are rendered
    - Forms of payment are cash, most credit and debit cards, and checks
    - Inability to make payments at the time of service may require your appointment to be rescheduled
    - Copays are collected at the time of check in
    - Deductibles, coinsurance and non-covered services must be paid at the time of service.
2. Insurance acceptance and filing
    - As a courtesy, we will file insurance if it is one in which Cook Chiropractic, Inc. is contracted.
    - Changes in insurance should be provided prior to your visit. Present your new insurance card so we can verify that we are contracted with the plan.
    - If you do not inform us of a change, and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balances.
    - All charges are your responsibility regardless of insurance. Any amount due after insurance pays is your responsibility and due upon notification.
3. Medicare members
    - Since it can be considered Medicare fraud to waive deductibles and copays, you will be billed these amounts following reimbursement.
4. Forms and records
    - There will be a $35.00 charge to fill out/complete any forms that are brought into Cook Chiropractic, Inc. This fee will be collected prior to completion of forms.
5. Returned Checks
    - Returned checks will incur a $35.00 fee. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card to prevent further action.
    - Once there has been a returned check, we will no longer accept personal checks.
    - Unpaid checks are filed in court and you will be required to appear before a judge and pay court costs.
6. Accounts turned over to a collection agency
    - Accounts with no payment activity for 120 days may be turned over to collections.
    - Temporary financial problems may affect timely payment so we encourage communication of such problems to us at 979-244-2900 so that your account can be properly managed.
7. Missed Appointments
    - Your appointments are booked at Cook Chiropractic, Inc. according to your condition and needs. Failure to keep your scheduled appointment can result in poor outcome of expected treatment results. Please notify the office 24 hours in advance if you cannot keep your appointment. We reserve the right to charge for missed appointments. Continued violation of this policy may result in dismissal from the clinic as poor treatment results are against the standards of Cook Chiropractic, Inc.

We are happy to help you maximize the allowable benefits with your health insurance plan. It is your responsibility to know and understand your own insurance benefits, coverage, pre-existing condition clauses, and referral/authorization requirements. We will assist when possible to help you in this often challenging endeavor. We look forward to serving your health care needs.

PARTIAL ASSIGNMENT OF THE CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

(Agreement)

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities (payers), which may elect, or be obligated to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of, Katherin Cook, DC/Cook Chiropractic, Inc., (or “Office”) in the amount of the full charges incurred by me at the Office, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office (“my charges”). I further grant a contractual lien to Katherin Cook, DC/Cook Chiropractic, Inc., with respect to my charges; however, I understand that nothing in this Agreement shall be constructed as an elect by Katherin Cook, DC/Cook Chiropractic, Inc. to claim protection under any statutory lien law. For the purposes of this Agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverage: individual/group health, disability, worker’s compensation, medical payments benefits, bodily injury, personal injury, personal injury protection, lost wages, lost services, no-fault benefits, uninsured and underinsured motorist coverage, liability coverage, property damage coverage, and malpractice coverage.

I further agree that, in the event a payer refuses to pay Katherin Cook, DC/Cook Chiropractic, Inc., I hereby assign to the office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to Katherin Cook, DC/Cook Chiropractic, Inc., as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Offices name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to Katherin Cook, DC/Cook Chiropractic, Inc. regarding my charges. Upon issuance, I agree that such letters of protection cannot be revoked or modified without the expressed written consent of the office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon request.

I hereby authorize and direct Katherin Cook, DC/Cook Chiropractic, Inc. to file my claim with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g. liability, medpay, attorneys, etc.), I hereby authorize and direct Katherin Cook, DC/Cook Chiropractic, Inc. to collect any write-offs or discounts, issued by health insurance, out of the proceeds from the other insurance or source of payment.

I hereby direct all payers to release to Katherin Cook, DC/Cook Chiropractic, Inc., any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate coleection under this agreement.

I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Katherin Cook, DC/Cook Chiropractic, Inc. to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Katherin Cook, DC/Cook Chiropractic, Inc. to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, and my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Katherin Cook, DC/Cook Chiropractic, Inc. for their services. This agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Katherin Cook, DC/Cook Chiropractic, Inc. for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of Katherin Cook, DC/Cook Chiropractic, Inc. Specialty Group and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Katherin Cook, DC/Cook Chiropractic, Inc. and myself. However, should any provisions of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason ceases to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print)____

Patient Signature____Date:_______/_______/__________

Name of Custodial Parent or Legal Guardian (please print)____

Parent /Guardian Signature:______________________________________Date:_____/______/__________

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Patient Signature____Date:_______/_______/__________

Name of Custodial Parent or Legal Guardian (please print)_______________________________________

Parent /Guardian Signature:_____________________________________Date:_____/______/__________